BENCH BRIEFS

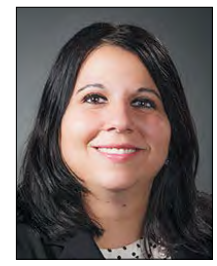
By Elaine Colavito

Suffolk County Supreme Court

Honorable Paul J. Baisley, Jr.

Petition to dismiss denied; notice of petition in a special proceeding must comply with the strict statutory mandates for obtaining personal jurisdiction when served.

In *Shoji Homes, LLV c. Mast Landscaping, Corp.,* Index No.: 607826/2019, decided on Aug. 20, 2019, the court denied the petition to dismiss the mechanic's lien. In rendering its decision, the court noted that the petitioner moved for dismissal, asserting that the respondent did not possess a valid license with the Town of Southampton when the work was performed. The affidavit of service reflected that the respondent was served with the notice of petition and petition via regular mail on April 23, 2019. In denying the motion, the court noted that CPLR §403(c) provides that a notice of petition shall be served in the same manner as a summons in an action. A notice of petition in a special proceeding must comply with the strict statutory mandates for obtaining personal jurisdiction when served. As the respondent was not properly served, petitioner's application to dismiss was denied.


Elaine Colavito

Honorable William G. Ford

Motion to vacate default judgment granted to extent that judgment was vacated pending further proceedings; issue of fact as to service/jurisdiction.

In *Livingston Financial, LLC v. Justin M. Raynor,* Index No.: 24539/2008, decided on Aug. 23, 2019, the court granted the motion to vacate the defendant's default and subsequent money judgment.

In rendering its decision, the court noted that here, given the conflict between the prima facie proof offered by plaintiff on the question of service of process and jurisdiction over the defendant, countered by defendant's sworn affidavit testimony denying receipt of said process, denying having resided at the service location, all offered in support of establishing excusable default, the court was constrained to find that a triable issue of fact existed, which would only be resolved at a traverse hearing. The court continued and stated that if defendant was indeed correct that the money judgment under review enjoyed no support from proper service, then equity demanded vacatur and a resolution of each parties' position on the merits.

Motion for leave to serve a late summons and complaint granted; defendants did not appear to suffer prejudice and as of now, the action was timely under the applicable statute of limits.

In *Jose Saravia v. Jesus Jr. Auto Repair, Inc., Chelsea Real Properties III, LLC & MSM Auto Repair, Inc.,* Index NO.: 602631/2017, decided on May 6, 2019, the court granted the motion for leave to serve a late summons and complaint. The court noted that plaintiff electronically commenced this premises lia-

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APPELLATE

Warning Signs from the Second Department

By Cory Morris and Glenn Warmuth


Cory Morris


Glenn Warmuth

Great changes are being made at the Second Judicial Department in the Supreme Court, State of New York. Practitioners who do not become familiar with these new rules may suffer money sanctions or perhaps worse.

New rules were promulgated to expedite appeals and eliminate waste from the court's already congested calendar. 22 NYCRR Part 1250.2(c) requires that: "The parties or their attorneys shall immediately notify the court when there is a settlement of a matter or any issue therein or when a matter or any issue therein has been rendered moot…" *Id.* "This subdivision, by its plain language, is applicable to both 'the parties' and 'their attorneys' and it imposes a continuing obligation to monitor the status of the case and to apprise the Appellate Division of certain developments that might affect a pending appeal."[1]

Under the old rule[2] the court issued 10 orders to show cause initiating an inquiry regarding sanctions over a period of 20 months. They then issued sanctions in eight of those cases which ranged from 250 to 500. When the Second Judicial Department issued sanctions, both the appellant's attorneys and respondent's attorneys were sanctioned in such instances.

Aside from the enormous change that came with electronic filing, the Appellate Courts wish to eliminate appeals from their dockets that were resolved. The Second Department recently held that "*all of the parties and their attorneys* are independently responsible for ensuring that timely notification occurs [and] Where…timely notification is not given by any of the parties or their attorneys, they may each be held independently responsible and, absent a showing of good cause for the failure to ensure a timely notification, sanctioned for their respective conduct."[3] In *Bank of NY*

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TRUSTS AND ESTATES UPDATE

By Ilene Sherwyn Cooper

Pleading

In *In re Caridi,* the Surrogate's Court, New York County, dismissed the amended objections to an accounting on the grounds that they were vague and incomprehensible, and thus failed to give the fiduciary fair notice of the claims against him. In support of his motion to dismiss the movant alleged that the amended objections did not single out any particular entry in the account or refer to any specific action of the trustee as imprudent or unreasonable. He argued that it was therefore impossible for him to respond to same. The court found that the amended objections contained allegations that were general and conclusory in nature and failed to meet the requirements of pleading within the scope of SCPA 302; to wit, that a pleading be "sufficiently particular to give the court and parties notice of the claim, objection or defense."

***In re Caridi,* NYLJ, July 19, 2019, at 24 (Sur. Ct. New York County).**

Removal of preliminary executor

In a contested probate proceeding, the decedent's spouse objected to the preliminary executor's request for an extension of his letters and requested that the Public Administrator be appointed the temporary administrator of the estate in his place and stead. The record reflected that the preliminary executor and the objectants had been engaged in disputes and litigation for years prior to and following the decedent's death, and that the animus between the parties was so severe that it was disrupting the administration of the estate. The court noted that the testator's nomination of a fiduciary should only be nullified upon a showing that the statutory grounds for disqualification clearly exist, and that disharmony in itself would not constitute grounds for disqualification. Nevertheless, under the circumstances, and in an effort to move the estate forward, the court opined that the testator's wishes for the appointment of a fiduciary had to yield to a third party. Accordingly, the preliminary executor's request was denied, and the Public Administrator was appointed temporary administrator of the estate.


Ilene Sherwyn Cooper

***In re Harris,* NYLJ, July 2, 2019, at 23 (Sur. Ct. Bronx County).**

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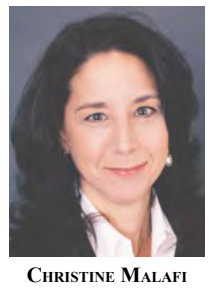
LABOR AND EMPLOYMENT

Legal Issues Surrounding Workplace Bullying

By Christine Malafi


Christine Malafi

According to a 2017 Workplace Bullying Institute survey, 19 percent of workers had experienced bullying in the workplace and another 19 percent had witnessed it. Applied to the total workforce, these percentages translate to about 60 million workers.[1] The #MeToo movement has brought renewed attention to the alarming prevalence of sexual harassment and assault, causing many employers to revisit their anti-sexual harassment policies and procedures. Employers should also take this opportunity to examine their workplace anti-bullying policies — or create them in the first place — as workplace bullying is unfortunately also not an uncommon problem.

Workplace bullying can be defined as persistent, malicious, unwelcome, severe and pervasive mistreatment that harms, intimidates, offends, degrades or humiliates an employee, whether verbal, physical or otherwise, at the place of work or in the course of employment. Unlike workplace anti-sexual harassment policies, companies are usually not required by law to have anti-bulling policies — but they would be wise to, so when issues inevitably arise, there are clear guidelines that leave little room for confusion, interpretation and disagreement.

A complete anti-bullying policy contains five elements: definition, examples, reporting procedure, investigation procedure and disciplinary action.

Definition

In addition to the description above, workplace bullying can also be defined more generally as any words or actions that make an employee feel uncomfortable, threatened, or intimidated, or that interfere with others' work or prevent work from getting done.

Examples

It is important for employers to provide concrete examples of workplace bullying to eliminate confusion and be as clear as possible in an effort to maintain the integrity of the policy. The list of examples should address issues such as: name-calling; persistent phone calls, emails, or other communications; unreasonable public criticism; exclusion from meetings or social situations; destructive gossip/rumors; intentional interference or sabotage of one's work; stalking; etc. There are endless potential forms of bullying, and any list of examples should include a disclaimer that the list is merely illustrative and not exhaustive.

Reporting procedure

Reporting procedures should generally follow that of the company's anti-sexual harassment policy, with a clear indication that

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Mellon v. Smith, 2019 N.Y. Slip Op 6228 (2nd Dep't. 2019), the Second Department issued sanctions where both parties knew and had reason to know that a calendared matter had settled yet did not inform the court of the same. The Second Department issued monetary sanctions, to both sides, in a published opinion.

Under the new rule (22 NYCRR 1250(c)), the Second Judicial Department issued 12 orders to show cause over a period of 13 months, double rate discussed above. However, more importantly, the Second Judicial Department issued five such inquiries under 22 NYCRR 1250(c) in October 2019. Many of these inquiries are not yet decided. In the cases that were decided the sanctions have increased and are sometime as much as $1,000 and, additionally, clients are now subject to sanctions. Lastly, in the past these were motion decisions; however, in *Bank of New York Mellon v. Smith,* the Appellate Division issued an opinion rather than a motion decision. The opinion can easily be accessed and serves as strong medicine for those who violate this rule.

Practitioners should prepare themselves. This Second Judicial Department in Bank of NY Mellon v. Smith, 2019 N.Y. Slip Op 6228 (2nd Dep't. 2019) made clear that the "primary purposes of section 1250.2(c) of the Rules of the Appellate Division, All Departments (22 NYCRR), which is to protect the Appellate Courts from spending time analyzing matters that have been rendered academic." Sanctions are increasingly being issued and clients are exposed to the ramifications of these rules.

The appellate rules, 22 NYCRR Part 1250[4], are applicable to all appellate courts in New York state and require that: "(c) Notice of Change of Circumstances. The parties or their attorneys shall immediately notify the court when there is a settlement of a matter or any issue therein or *when a matter or any issue therein has been rendered moot*. …Any party or attorney who, without good cause shown, fails to comply with the requirements of this subdivision may be subject to the imposition of sanctions."[5] Arguably, this imposes a duty on both sides to make known to the court when an issue of law was brought before the court and a decision rendered or that there has been a change in circumstances where the appeal is no long viable or, as the rule states, moot.

The key takeaway here for practitioners is to avoid the problem. It is incumbent upon appellate practitioners to inform the court of when a matter has been rendered moot. If one's adversary is unwilling to comply with the rule, motion practice may be necessary. Practice with precaution.

Note: Named a SuperLawyer, Cory Morris is admitted to practice in NY, EDNY, SDNY, Florida and the SDNY. Mr. Morris holds an advanced degree in psychology, is an adjunct professor at Adelphi University and is a CASAC-T. The Law Offices of Cory H. Morris focuses on helping individuals facing addiction and criminal issues, accidents and injuries, and, lastly, accountability issues.

Note: Glenn P. Warmuth is a partner at Stim & Warmuth, P.C. where he has worked for over 30 years. He has served as a director of the Suffolk County Bar Association and as an officer of the Suffolk Academy of Law. He is currently co-chair of the Appellate Practice Committee and co-coordinator of the Suffolk County High School Mock Trial Competition. He can be contacted at gpw@stim-warmuth.com.

(Endnotes)
1 Bank of NY Mellon v. Smith, 2019 N.Y. Slip Op 6228 (2nd Dep't. 2019) (citing 22 NYCRR 1250.2(c)).
2 22 NYCRR 670.2(g).
3 Bank of NY Mellon v. Smith, 2019 N.Y. Slip Op 6228 (2nd Dep't. 2019) (emphasis added).
4 Available at: https://www.nycourts.gov/courts/AD1/Practice&Procedures/rules.shtml#1250.2.
5 Id. (emphasis added)

Health and Hospital (Continued from page 8)

late" to self-funded employee benefit plans and do not alter, modify, expand or impact upon the administration of plan benefits since the plan no longer is involved once it pays or denies its portion of the claim.

On Oct. 17 the governor signed Chapters 375 and 377 of the Laws of 2019, expanding the definitions of "provider" to include hospitals. The dispute resolution processes established in the current law will now apply to hospital bills for out-of-network *emergency services* as well as inpatient services resulting from the precipitating emergency department visit. (The law only covers "emergency" bills since by definition there never can be a "surprise" hospital bill.)

Keep in mind that the process is available for out-of-network bills or in cases where the patient is uninsured. It is not intended to allow a patient to contest the amount of a bill submitted to his or her in-network health plan (the amount of which directly affects the patient's personal cost share, which can be substantial for a hospital bill in this era of "high deductible" plans); that is a benefit dispute issue between the member and the plan, not the provider.

As I previously discussed, the bad news is that the ability to "balance bill" an out-of-network patient for the hospital's full retail charges usually resulted in full payment being made by the health plan, since both New York and federal law compel the health insurer or plan "hold harmless" the emergency care patient from any liability for the actual emergency related charges. Denying the hospital this leverage means that the hospital's only resort is to take advantage of the standing the new law gives to hospitals to file for an IDRA determination and live with the decision. In addition to the trouble and expense, the finding here, as with the current law covering doctor and ancillary provider billing disputes, is "all-or-nothing;" either the actual payment made by the out-of-network plan or the total hospital bill is deemed by the agent to be the more "reasonable." (Only in the uninsured case where the patient presumably has to pay all of it can the agent "split the baby" and make a *de novo* determination of reasonableness.)

Is there any good news for hospitals? Not much. Under the new law health plans must honor assignments of benefits for emergency services and provide payment directly to the non-participating hospital. This addresses the rather nasty practice of some plans to try to push out-of-network hospitals into a network agreement by sending checks to the patients. Plans also are required to pay out-of-network hospitals an amount that is at least 25 percent greater than the most recent contractual in-network rate that the hospital and the health plan may have had in effect in the past 12 months, but which presumably now has expired or been terminated by the parties. If the previous contract expired or was terminated more than 12 months prior to the claim submission, then the last contracted rate is adjusted based on the "Medical Consumer Price Index" as of the claim submission date.

Here is the tricky part. In circumstances where the plan and the hospital had never previously contracted for in-network participation then the health plan pays an amount that the plan unilaterally determines to be reasonable, yet at the same time the law requires that it continue to hold the patient harmless from the hospital's balance billing. While nothing in the law precludes either the health plan or the hospital from submitting this payment dispute to IDR the unanswered question is whether the hospital instead may elect to balance bill the patient? No one seems to know.

In determining the reasonableness of either the hospital's bill or the plan's payment the IDRA must consider whether there is a gross disparity between the hospital's charge and the fees paid to the hospital by other plans for similar services in out-of-network situations, or the fees paid by the insurer to similar non-participating hospitals; the expertise of the hospital, including teaching status, scope of services, and the different kinds of health plans the hospital's patient may have (commercial, Medicare, Medicaid, etc.); and the hospital's usual retail charge for comparable services covered by other health plans with which it does not participate. (This calls into question both the legality and the ability of hospitals to disclose negotiated rates and other terms and provisions unique to each network agreement and generally considered to be proprietary and confidential.)

Two other points of interest. Hospitals and state regulated health plans that are unable to reach terms on an extension of a network agreement, or that elect to terminate an agreement, are compelled to enter into a 60-day post expiration/termination "cooling off" period, during which time the terms and conditions of the agreement must continue to be honored and patients treated as if in-network, notwithstanding that the contract legally has ceased to exist. In theory this will compel the parties to keep talking and maybe come to terms. The same idea has been incorporated into the new law with the requirement that the parties to utilize a nonbinding mediation process at least 60 days *prior* to the termination or expiration of a contract.

If the new law will result in most out-of-network payments being lower than in-network rates why would any plans want to keep hospitals in-network for emergency services?

Also, the expansion of the IDR process does not apply to hospitals where at least 60 percent of their discharges are Medicaid beneficiaries, uninsured patients or patients dually eligible for Medicare and Medicaid. The contract mediation requirement, however, still applies.

This whole process is a "win" for health insurers and plans. While the bills were still under consideration in the legislature hospitals repeatedly pointed out that the existence of current laws requiring health plans to hold harmless any out-of-network emergency care patients has adequately protected the healthcare consumer community. Evidently not, since the positions of the insurance and health plan lobbies apparently prevailed. In addition, while the law allows access to the IDA process both by the payer and the provider, the practical reality is that health plans never will have to appeal; they simply will issue payment in whatever amount they want, which compels the hospital to go to the trouble of filing if it wants a "reasonable" payment (unless, of course, the hospital elects to balance bill the patient, to date an unsettled and very "iffy" proposition). Also, and this is the current concern, the formulas established in the law for payment of emergency claims very well may be, and anecdotally often are, less than the rates of payment currently established in most network agreements. In the "old days" insurers and plans wanted hospitals to be in-network for emergency services precisely because the plans' payment liabilities were based on full retail charges. If the new law will result in most out-of-network payments being lower than in-network rates why would any plans want to keep hospitals in-network for emergency services? Will hospitals start seeing more and more benefit designs or health plan-driven contract templates being drafted in a way that excludes emergency claims from in-network coverage altogether? Can hospitals afford to drop major health insurers and plans altogether just because emergency services have been carved out of their network agreements? What will the consequences be for patients? These are questions that have yet to be answered.

All of this because lawmakers perceive that this is a politically important consumer rights issue. Maybe they're right. But let's hope that the cure isn't worse than the disease.

Note: James Fouassier, Esq. is the Associate Administrator of Managed Care for Stony Brook University Hospital. He is a past co-chair of the Association's Health and Hospital Law Committee. His opinions and comments are his own. He may be reached at james.fouassier@stonybrookmedicine.edu.